COMMUNITY
HEALTH
ALLIANCE

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Social Security Number:	DOB: / /

Street Address:	City:	State:	Zip:
Cell Phone: ☐ Preferred	Home Phone: ☐ Preferred	Work Phone: ☐ Preferred	Email: ☐ Decline

Marital Status: ☐ Child ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Student: ☐ Yes ☐ No

Race Group: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐ Pacific Islander ☐ Native Hawaiian | Ethnic Group: ☐ Hispanic ☐ Non-Hispanic

Preferred Language: ___________________ | Hearing Impaired: ☐ Yes ☐ No | Visual Impaired: ☐ Yes ☐ No

Need Translator: ☐Yes ☐No | Need Translator: ☐ Yes ☐ No

Sexual Orientation:
☐ Straight or Heterosexual ☐ Bisexual
☐ Lesbian, Gay, Homosexual ☐ Other, Specify _____________
☐ Unknown ☐ Decline to answer

What is your current gender identity? (please check all that apply)
☐ Male ☐ Female
☐Transgender male ☐ Transgender female
☐ Genderqueer, neither exclusively male nor female
☐ Other, please specify_______________________ ☐ Decline to answer

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired | Occupation:

Employer:	Address:

Emergency Contact:	**Phone Number:**	**Relationship:**

Public Housing: ☐ Yes ☐ No Emergency Shelter ☐ Yes ☐ No Transitional ☐ Yes ☐ No ☐ Other

Homeless: ☐ Yes ☐ No Street ☐ Yes ☐ No Doubling Up ☐ Yes ☐ No ☐ Unknown

How did you hear about us? ☐ Brochure/flyer ☐ Family/Friend ☐ TV ☐ Radio ☐ Newspaper/Magazine ☐ Website/Online ☐ Social Media ☐Health Event ☐Other:______

RESPONSIBLE PARTY

Last Name:	First:	MI:	☐ Male ☐ Female	Marital Status:

Address: (If Different)	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:
Social Security:	Date of Birth:	Relationship to Patient: ☐ Spouse ☐ Parent ☐Other:______
Employer:	Employment Status: ☐ Full-time ☐ Part-time ☐Other:________	Occupation:

Employer Address:	City:	State:	Zip:

PRIMARY INSURANCE

Primary Insurance Company:	Insurance ID Number:	Occupation:
Insurance Policy Holder's Name: (If different)	Relationship to Patient:	Insurance Group Number:

Social Security Number:	Birth Date:	Primary Phone:	Work Phone:

Employer:	Employer Phone:	Employment Status: ☐ Full-time ☐ Part-time ☐Other:_________

Employer Address:	City:	State:	Zip:

SECONDARY INSURANCE

Secondary Insurance Company:	Insurance ID Number:	Occupation:
Insurance Policy Holder's Name: (If different)	Relationship to Patient:	Insurance Group Number:

Social Security Number:	Birth Date:	Primary Phone:	Work Phone:

Employer:	Employer Phone:	Employment Status: ☐ Full-time ☐ Part-time ☐Other:_________

Employer Address:	City:	State:	Zip:

Chart Number:	CHA Staff (Print Name):	Date:

V. 10-21-16

COMMUNITY
HEALTH
ALLIANCE

Print Patient Name: ______________________________

Date of Birth: ______________________________

Consent for Treatment

_____ (Patient initials) I give permission to receive outpatient care at Community Health Alliance (CHA), including routine examinations, minor diagnostic and surgical procedures performed by the CHA Medical/Dental Staff.

Missed and Late Appointments Policy

_____ (Patient initials) I received, read and understand the CHA policies about Missed and Late Appointments, and my questions were answered by CHA staff. **(Page 5)**

Patient Rights and Responsibilities

_____ (Patient initials) I received, read and understand the Patient and Health Center Rights and Responsibilities, and my questions were answered by CHA staff. **(Page 6)**

Chronic Pain Management Policy

_____ (Patient initials) I received, read and understand CHA policy that no chronic pain management services with opiate-based medications will be provided, and my questions were answered by CHA staff. **(Page 7)**

Acute Pain Controlled Substance Policy

_____ (Patient initials) I received, read and understand CHA policy regarding acute pain controlled substances, and my questions were answered by CHA staff. **(Page 7)**

Dental Procedure Policy

_____ (Patient initials) I received, read and understand CHA policy regarding dental procedure, and my questions were answered by CHA staff. **(Page 8)**

Consent for Billing

_____ (Patient initials) All co-payments, deposits and sliding fees are due and payable at the time of check-in. I assign all insurance payments to be made directly to CHA. This authorization and assignment is a permanent, one-time signature. I reserve the right to revoke this at any time with my written notice. **(Page 9)**

Consent to Test in the Event of a Healthcare Worker Exposure (CHOOSE ONE):

_____ (Patient initials) I give permission for the performance of a blood test to detect antibodies for HIV.

_____ (Patient initials) I refuse to give permission for the performance of a blood test to detect antibodies for HIV. **(Page 9)**

Verification that you have received the "New Patient Orientation Packet"

_____ (Patient initials) I received, read and understand the New Patient Orientation Packet, and my questions were answered by CHA staff.

I prefer to be contacted by:

_____ Text (Dental only) _____ Mail _____ Letter _____ Postcard _____ Patient Portal

_____ Home Phone _____ Cell Phone _____ Work Phone _____ Other

Can confidential messages be left on your telephone answering machine/voice mail? _____ Yes _____ No

All other HIPAA information addressed in your privacy notice has separate CHA policies and forms that must be referenced and signed by the patient or legal guardian.

Signature of Patient, Parent or Legal Guardian: ______________________________

Date: ______________________________

CHA Staff Signature: ______________________________

COMMUNITY HEALTH ALLIANCE

PEDIATRIC HEALTH HISTORY

Patient Name:	DOB:	Date:

Main reason for today's visit:

Where were you getting your MEDICAL care before? (Previous doctor/PCP):

Where were you getting your DENTAL care before? (Dentist):

In the past 2 weeks, have you been bothered by:
Little interest or pleasure in doing things? ☐Yes ☐No
Feeling down, depressed or hopeless? ☐Yes ☐No

Review of symptoms: *Please mark the box (✓) and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.*

General	Respiratory	Gastrointestinal	Psychiatric
☐ Unexplained weigh loss/gain ☐ Unexplained fatigue/weakness ☐ Fever, chills ☐ **No problems**	☐ Altered breathing during sleep ☐ Cough/wheeze ☐ Loud snoring ☐ **No problems**	☐ Heartburn/reflux/indigestion ☐ Blood or change in bowel movement ☐ Constipation ☐ Poor appetite ☐ **No problems**	☐ Anxiety/stress/irritability ☐ Sleep problems ☐ Lack of concentration ☐ Hyperactivity ☐ **No problems**
Skin	**Hematologic/Lymphatic**	**Eyes**	**Allergy/Immune**
☐ New or change in a mole ☐ Rash/itching ☐ **No problems**	☐ Swollen glands ☐ Easy bruising ☐ **No problems**	☐ Change in Vision ☐ Eye pain/redness ☐ **No problems**	☐ Hay fever/allergies ☐ Frequent infections ☐ Lowered immune system ☐ **No problems**
Neurological	**Genitourinary**	**Ears/Nose/Throat**	**Women only**
☐ Headache ☐ Fainting/dizziness ☐ Numbness/tingling ☐ Unsteady gait ☐ **No problems**	☐ Nighttime urination or increase frequency ☐ Discharge; penis or vagina ☐ **No problems**	☐ Nosebleed ☐ Frequent sore throat ☐ Hearing loss ☐ Ringing in ears ☐ **No problems**	☐ Pre-menstrual symptoms(bloating, cramps, irritability) ☐ Problem with menstrual periods ☐ **No problems**
Cardiovascular	**Musculoskeletal**	**Endocrine**	**Breast**
☐ Chest pain/discomfort ☐ Palpitations(fast or irregular heart beat) ☐ **No problems**	☐ Neck pain ☐ Back pain ☐ Muscle/joint pain ☐ **No problems**	☐ Heat or cold sensitivity ☐ **No problems**	☐ Breast lump/pain ☐ Nipple discharge ☐ **No problems**

MEDICATIONS: ____

Please list(or show us your own printed record) all prescription and non-prescription medications, vitamins, home remedies, birth control pill, herbs, inhalers, etc. use back of this form if you need more room.

☐ Blood thinning medications ☐ Dietary or herbal supplements ☐ History of aspirin therapy
☐ History of steroid therapy ☐ Osteoporosis medication ☐ Check here if you have listed more
☐ TAKE NO MEDICATIONS

MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?	MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?

Allergies or intolerance to medications (include type of reaction):____

Are you allergic to the following? DK (Don't know)

Latex ☐Yes☐No☐DK	Metals ☐Yes☐No☐DK	Local anesthetic ☐Yes☐No☐DK	Iodine ☐Yes☐No☐DK
Ibuprofen ☐Yes☐No☐DK	Sulfa/Sulfite ☐Yes☐No☐DK	Codeine ☐Yes☐No☐DK	Aspirin ☐Yes☐No☐DK
Penicillin ☐Yes☐No☐DK	Other ANTIBIOTICS ☐Yes☐No☐DK	Other ☐ ____________	None ☐

PERSONAL MEDICAL HISTORY: Do you have now (current) or have had (past) any of the following conditions?

CONDITION	CODE	CURRENT	PAST	CONDITION	CODE	CURRENT	PAST
ADD/ADHD				Hepatitis			
Alcohol/Drug abuse	F10.10/f19.10			High Blood Pressure	I10		
Anemia	D64.9			High Cholesterol	E78.0		
Anxiety	F41.9			History of heavy bleeding			
Asthma	J45.909			If you have HIV infection, do you have AIDS			
Bladder/Kidney problems				Kidney Disease/Failure chronic	N18.9		
Bleeding disorder				Low Blood Pressure			
Blood clot (leg)	I82.409			Migraine Headaches	G43.909		
Blood clot (lung)	I26.99			Pneumonia	J18.9		
Blood transfusion—other complication	T80.89XA			Psoriasis			
Chicken pox	B01.9			Psychological Treatment	L40.9		
Congenital Methemoglobinemia				Respiratory Problems			
Depression	F32.9			Rheumatic Fever			
Diabetes (childhood onset) type 1	E10.9			Seizure/Epilepsy			
Do you have active Tuberculosis/TB				Sinus Problems			
Do you have HIV infection				Sleep Apnea	G47.30		
Eating Disorders (anorexia, bulimia, etc.)				Special needs			
Emphysema	J43.9			Stomach Ulcer	K25.9		
Fractures (broken bones)				Stroke	I63.9		
Gastroesophageal Reflux (heartburn/GERD)	K21.9			Swollen Ankles			
Gynecological conditions				Thyroid High (overactive) Hyperthyroidism	E05.90		
Heart Murmur				Thyroid Low (underactive) Hypothyroidism	E03.9		
Heart or Valve Defect							

Other (list):

Has your child ever been hospitalized? ☐ Yes ☐ No If yes: Date:__________________ Reason for Hospitalization:________________________________

Does your child have any disabilities? ☐ Yes ☐ No If yes: Do you need any accommodations? ☐ Yes ☐ No

If yes, please specify:____

BIRTH AND PREGNANCY

What city was your child born in? ______________________________ Name of hospital: ______________________________

Is this your child by: ☐ Birth ☐ Adoption ☐ Step-child ☐ Other: ______________________________

Birth weight: ________________ Was your baby premature? ☐ Yes ☐ No

Were there any significant medical problems during your pregnancy? ☐ Yes ☐ No

Were there any significant complications during labor or the baby's newborn period? ☐ Yes ☐ No

If yes, to any of the above questions, please explain:

____

How long was your child breast-fed? ☐N/A ☐less than 6 months ☐6-11mo ☐12-17 mo ☐18-23mo ☐2 years or more

How long was your child bottle-fed?☐N/A☐ less than 6 months ☐6-11mo ☐12-17 mo ☐18-23mo ☐2 years or more

Do/Did you feed your child infant formula? ☐Yes ☐No If Yes, what type? (check one)☐ready to use☐powdered ☐Liquid Concentrate

Does/Did your child sleep with a bottle? ☐Yes ☐No If Yes, content of bottle? __________________

Does/Did your child use a no-spill training cup (sippy cup)? ☐Yes ☐No

Child's age (in months) when first tooth appeared in mouth __________

Has your child experience any teething problems? ☐Yes ☐No

When did you begin brushing his/her teeth?☐N/A ☐less than 6 months☐6-11mo ☐12-17 mo ☐18-23mo☐2 years or more

When did you begin using tooth paste? ☐N/A ☐less than 6 months ☐6-11mo ☐12-17 mo ☐18-23mo☐2 years or more

Who is your child's primary care taker during the day? ____________________ During the evening? ______________________________

Name/age of siblings at home:____

GROWTH AND DEVELOPMENT

Have you or your prior pediatrician ever had any concerns about your child's growth or development (speech/language, social skills, motor skills,

etc.)? ☐ Yes ☐ No
If yes, please explain: ______

Girls only: Age at first period: ______ Are you pregnant? ☐ Yes ☐ No

PAST MEDICAL HISTORY

HAS YOUR CHILD:

Had any serious medical illness? ☐ Yes ☐ No
Had a history of asthma or wheezing? ☐ Yes ☐ No
Ever used an inhaler or nebulizer? ☐ Yes ☐ No
Had surgery? ☐ Yes ☐ No
Bed bugs? ☐ Yes ☐ No
Had broken bones/frequent or severe sprains? ☐ Yes ☐ No
Had any mental or behavioral problems? ☐ Yes ☐ No
Had a positive tuberculosis test? ☐ Yes ☐ No
Been hospitalized overnight? ☐ Yes ☐ No

If yes, to any of the above, please explain: ______

DENTAL HISTORY

Do your gums bleed when you brush or floss?	☐Yes ☐No ☐DK	Do you have earaches or neck pain?	☐Yes ☐No ☐DK
Are your teeth sensitive to the cold, hot, sweets or pressure?	☐Yes ☐No ☐DK	Do you have any clicking, popping or discomfort in the jaw?	☐Yes ☐No ☐DK
Are you experiencing dental pain or discomfort?	☐Yes ☐No ☐DK	Do you brux (clench) or grind your teeth?	☐Yes ☐No ☐DK
Does food or floss catch between your teeth?	☐Yes ☐No ☐DK	Do you have any sores or ulcers in your mouth?	☐Yes ☐No ☐DK
Do you have any oral piercings/jewelry?	☐Yes ☐No ☐DK	Oral habits(chewing finger nails, clenching,etc)	☐Yes ☐No ☐DK
Is your mouth dry?	☐Yes ☐No ☐DK	Do you wear dentures or partials?	☐Yes ☐No ☐DK
Have you had any periodontal (gum) treatments?	☐Yes ☐No ☐DK	Do you participate in active recreational activities?	☐Yes ☐No ☐DK
Have you ever had orthodontic (braces) treatment?	☐Yes ☐No ☐DK	Do you play contact sports?	☐Yes ☐No ☐DK
Do you bleach your teeth?	☐Yes ☐No ☐DK	Do you wear a mouth guard when playing contact sports?	☐Yes ☐No ☐DK
Have you had any problems associated with previous dental treatment?	☐Yes ☐No ☐DK	Have you ever had a serious injury to your head or mouth?	☐Yes ☐No ☐DK

How many times do you brush daily? ______

How many times do you floss daily? ______

How do you feel about your smile? ______

Is your home water supply fluoridated? ☐Yes ☐No ☐DK

Do you drink bottled water or filtered water? ☐Yes ☐No ☐DK
If yes, how often? Circle one: ☐Daily ☐ Weekly Occasionally

How many 8 oz servings of the following do you drink a day?
100% juice☐ Fruit drinks or sports drinks(Gatorade)☐ Soda punch☐ Water☐ Whole milk☐
Energy Drinks (Rockstar,Monster)☐ Nonfat or reduced fat milk☐

Date of your last dental exam: ______
What was done at the time: ______
Date of last X-rays: ______

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐No ☐DK

Name of physician or dentist making recommendation: Phone:

IMMUNIZATIONS

Please bring your child's immunization records to your appointment

Have you ever refused vaccines for your child? ☐ Yes ☐ No
If yes, why?
______

FAMILY HISTORY-Indicate which relative has had the following disease (parents and siblings are most important)

Are you adopted and have no known family history? ☐Yes ☐No

Disease	Mother	Father	Brothers	Sisters	Moms Mom	Moms Dad	Dads Mom	Dads Dad	Other Relative	Disease	Mother	Father	Brothers	Sisters	Moms Mom	Moms Dad	Dads Mom	Dads Dad	Other Relative
No significant history known										High Blood Pressure/Hypertension									
Alcohol abuse										High Cholesterol									
Asthma										Hypothyroidism/Thyroid Disease									
Autoimmune Disease										Illegal drug abuse									
Bleeding or Clotting Disorder										Kidney Disease									
Depression/Suicide/Anxiety										Migraine Headaches									
Diabetes (adult onset) type2										Seizures/Epilepsy									
Diabetes (childhood onset) type 1										Prescription drug abuse									
Genetic Disorder (explain)										Stroke/CVA									
Heart Disease										Developmental disorders									
										No significant history known									

OTHER HEALTH ISSUES

Safety:

Do you use a bike helmet? ☐ Yes ☐No

Do you use seatbelts consistently? ☐ Yes ☐No

Does your home have a working smoke detector? ☐ Yes ☐No

If you have guns in your home, are they locked up? ☐ Yes ☐No

Is violence at home a concern for you? ☐ Yes ☐No

Exercise:

Does your child exercise regularly? ☐ Yes ☐ No

What kind of exercise? ____________________

How long? (min)____________ How often? ________

How would you rate your child's diet?

☐ Good ☐ Acceptable ☐ Poor

Would you like advice on your child's diet? ☐ Yes ☐ No

Leisure activities, group involvement, religion, volunteer work, recent travel:

____

____

Education Level:

Current or Highest grade completed: ____________

Annual household income: ____________

______________________________ ______________________________

Parent Signature Date

Renown
TeleHealth

Patient Authorization and Informed Consent To Participate in Telemedicine Consultation

Originating Site Information	Distant Site Information
Provider Name:	Provider Name:
Practice Name:	Practice Name:
Facility Name:	Facility Name:

1. **Purpose.** The purpose of this form is to obtain your consent to participate in a telemedicine consultation.

   As it pertains to said consent, I understand the following:

2. **Overview.** Telemedicine applies advanced videoconferencing technology to the healthcare delivery process, enabling urban medical providers and healthcare facilities ("Distant Sites") to provide virtual consultative services for rural patients, medical providers and facilities ("Originating Sites").

3. **Participants.** The consulting medical provider will be at a different location, and a separate healthcare provider will be at my location to assist with the consultation. I will be informed if the presence of any additional personnel is required, and I will give my verbal permission prior to their participation.

4. **Medical Information.** My healthcare provider shall transmit, share and discuss details of my medical history, examinations, diagnostic testing, photographs or other images with the consulting medical provider. The Originating and Distant Site healthcare providers shall keep a record of the consultation in their respective medical records.

5. **Monitoring.** Consultations may be monitored for clinical and administrative education, and continuous quality improvement.

6. **Confidentiality.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telemedicine consultation.

7. **Rights.** Telemedicine participation is voluntary, constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. My consent may be withheld or withdrawn at any time without affecting my right to future care or treatment.

8. **Acknowledgement.** The healthcare providers involved in my care have explained the telemedicine consultation process in a satisfactory manner, and answered all questions posed by me and/or my representative. Understanding the above:

☐ **I consent to the telemedicine consultation** ☐ **I do not consent to the telemedicine consultation**

Signatures	Date
Patient:	
Representative:	
Witness:	

Place signed consent in Originating and Distant Site medical records.

Authorization for Release/Disclosure of Protected Health Information:
This form may be used for continuity of care; treatment, payment and health care operations (TPO); and the release of protected health information (PHI) which is not required by law. Provide a copy to the patient/patient representative when Renown Health initiates the authorization for non-TPO reasons.

Notice to the individual making this authorization:

1. After your protected health information (PHI)/medical records are released by your authorization, the possibility exists that your PHI will no longer be subject to the protection of federal privacy regulations and may be redisclosed by the recipient.
2. You may revoke this authorization at any time in writing. Your written revocation will become effective upon receipt, but will not apply to any PHI released prior to that date or to the extent that the referenced Renown Health entity has taken action in reliance upon this authorization.
3. Renown Health will not condition treatment on whether you sign this form.

THIS AUTHORIZATION WILL EXPIRE 90 DAYS AFTER THE DATE OF SIGNATURE

Patient Name	Date of Birth	Social Security Number
Address		Phone
City, State, Zip		Fax

I authorize (you must check the blank that applies):
___The provider listed below to release/disclose the PHI described below to the above-referenced Renown entity
___The above-referenced Renown entity to release/disclose the PHI described below to:

Provider Name	
Address	Phone
City, State, Zip	Fax

Description of information to be released for the following dates of treatment/service:____________

___Physician generated data	___History and Physical	_____ Operative Report(s)
___Discharge Summary	___Discharge Instructions	_____ ER documents
___Diagnostic imaging	___Diagnostic data	_____ Labs
___Therapy evaluations/records	___Medication Records	_____ Consultation Report(s)

___Other (describe):____

NOTE: The use or disclosure of psychotherapy notes requires a separate authorization.

Reason for this request:______ Continuity of Care _____ Legal _____ Patient Request

_____ Other (describe):____

I understand that my PHI/medical records may contain information about:

- Drug and/or alcohol abuse history, diagnosis, treatment;
- Psychiatric history, diagnosis, treatment;
- AIDS/HIV, sexually transmitted diseases, hepatitis and/or other infectious disease history, diagnosis, treatment.

By signing below, I authorize the release/disclosure of my PHI even if it contains information regarding the above-listed types of information with the PHI/medical records requested.

Signature of patient or personal representative:	Date:
Print name of personal representative:	Representative's authority:

For Renown Health Personnel Use Only:

Renown Health Patient Medical Record No.	